The RHODE ISLAND MEDICAL JOURNAL

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VOL. XXVI DECEMBER, 1943 No. 12

SPEAKING FOR NEW ENGLAND

THE Medical Societies of the States of Rhode Island, Maine, New Hampshire, Vermont, Massachusetts, and Connecticut, through their properly appointed representatives, have studied Senate Bill 1161 now before the Congress of the United States, and they express themselves regarding this proposed legislation as follows:

We approve of the broad medical objectives of the Act that we interpret to be an attempt to improve the health of the people. As a basis of our approval we cite the progressive leadership which the physicians of New England have always shown in the development of public health enterprises. For more than fifty years we have consistently supported the plea for the establishment of a National Department of Health with a Secretary in the President's Cabinet, under whom would be coordinated many important public health programs, exclusive of the Army and Navy. These are now scattered through various departments and bureaus of the Federal government and already play a large role in the provision of medical care for the people of this country.

We approve of the use of the insurance principle on a voluntary basis as a means to aid the individual to budget against the cost of medical care. We maintain that when insurance programs are not directly under the supervision of the medical profession by whom medical care is to be rendered, they should provide for cash benefits to be paid to the individual, for we firmly believe that the citizens of New England are capable of using cash benefits to pay the cost of medical care.

We believe that S. 1161 does not provide for the sound development of a National Health Program. It is implied by the Act that the distribution of compulsory savings managed by Federal authorities will guarantee better health for all the people. We sincerely doubt that such an objective can be realized in this way. In the New England States, judged by any standards with which we are familiar, there is no need to revolutionize the habits of the people in their methods of obtaining medical care.

Private enterprises in the field of voluntary prepaid medical and hospital insurance are increasing rapidly. These facilities should be utilized by the States, if necessary through Federal grants-in-aid, so that each State can purchase medical care for those who are not able to purchase it for themselves. This we believe to be a development that would be acceptable to the New England people, for thereby medical care could be provided even for the indigent who are public charges, a provision most desirable in those communities that have been unable or unwilling to meet this obvious responsibility.

We shall be glad to work out plans with representatives of the Federal and State governments to improve the health of all the people, but we should expect that any plans that might be devised would take full advantage of existing agencies and should be developed within the social patterns that are well understood by the people.

THE REHABILITATION CENTRE

ALEXANDER P. AITKEN, M.D.

The Author. *Alexander P. Aitken, M.D., Chief, Supervisory Staff, The Rehabilitation Center of the Liberty Mutual Insurance Company; Member, American College of Surgeons; Member of the American Association for Surgery of Trauma; Diplomate of the American Board of Orthopedic Surgery.*

A COMPLETE industrial rehabilitation centre, which is the first of its kind, was founded in Boston by the Liberty Mutual Liability Insurance Company in June, 1943. The purpose of this institution was to provide for adequate medical aftercare in cases disabled as a result of an industrial accident. It was our feeling that many cases of prolonged or even permanent disability could be prevented, or at least the length of disability and the degree of residual disability lessened, if early and adequate therapy was given.

The immediate care, whether rendered in a doctor's office or at a hospital is usually promptly and adequately administered. However, when the patient is discharged home and becomes ambulatory, progress often slows up or ceases altogether. This may be due to several factors. In some instances the patient is not given or fails to perform any type of exercise, either for the body as a whole or for the injured member. Failure to perform the former results in an increase of body weight and a general loss of muscle tone, both of which definitely prolong the period of disability. Often the patient fails to exercise the injured part because of actual pain or fear of pain. More often the patient is given and does attempt to follow a prescribed series of exercises, but even in these cases little progress may be made, either because the patient has not been properly instructed in detail or his exercises have not been supervised. Patients soon learn to compensate for lost motion and may feel that they are exercising properly, while the injured part is actually not being moved. This failure to exercise the injured member results in increasing muscle atrophy and joint fixation. The longer either condition persists, the longer the period of disability and the poorer the chance of eventual restoration of normal function becomes.

Failure of physical improvement soon leads to deterioration in mental attitude. Fear that he may have lost his job, or even the more serious fear that he may never return either to his regular position or to any type of employment, lowers the individual's morale; as his depression deepens, he becomes less receptive to any type of treatment and is less apt to show the enthusiasm and cooperation so essential to his eventual recovery. As he cannot notice improvement, he becomes less diligent in his exercises. A vicious cycle is thus established, which is most difficult to break. It is the purpose of the Centre to give the patients adequate medical aftercare, whereby no opportunity for either physical or mental deterioration is given.

Importance of Medical Supervision

Careful medical supervision is imperative in the operation of such a centre. The great majority of cases will consist of fractures, amputations and injuries to joints, muscles, tendons, peripheral nerves and bursae. Consequently, the physician in charge should be well trained in the field of traumatic surgery. All patients must be carefully examined on admission and a complete diagnosis of the injury made. Not infrequently, the diagnosis with which the patient arrives may prove incorrect. Other conditions, such as reflex vascular spasm, may be present. The admitting physician thus must determine whether or not further surgery is needed before the patient attends the Centre. Many cases sent to the Centre are of several years' duration, having fixed joints and considerable muscle atrophy, and these cannot be rehabilitated. The surgeon, therefore, must determine which cases are and which are not to be admitted. In many cases residual deformity and loss of motion are inevitable; an appraisal then has to be made as to the amount of recovery that can be expected. When an end result has been reached, a decision has to be made as to when treatment should be discontinued. In some instances, although surgery may be indicated, it is often advisable to regain muscle power first. In other cases, it may be found during the course of treatment that surgery, which had not been anticipated, would prove beneficial. Finally, the surgeon must check the progress of each patient and direct the treatment according to the progress made. This work, at the present time, is

being carried out at the Centre by two orthopedic surgeons.

Departmental Organization of Centre

The Centre is made up of two correlated departments, comprising physical and occupational therapy. It is essential that both departments cooperate and be well aware of what each department is doing.

The physical therapy department is headed by a thoroughly trained physiotherapist, who has two assistants. The mechanical equipment is quite complete. Almost any form of physical therapy can be administered. Many cases, particularly when acute, must receive physiotherapy before they can be sent to the workshop.

The occupational therapy department is likewise headed by a trained technician who has a corps of assistants. In this department the patient does actual work, within his limitations to do so. Attention is focused on the lost motion and the work directed toward its recovery. It is our intention to eventually give each patient work to do which simulates his regular work as closely as possible. At the present time the patients build such objects as waste baskets, sewing cabinets, end tables, wall lamps, smoking stands and foot stools. The carpenter shop is complete. No power driven tools are used. The creation of these finished articles is a tremendous stimulus to the patient. The depressed, belligerent and complaining patient, once having found that he is able to use his hands, soon forgets the chip on his shoulder and a definite improvement in morale develops. Often the patients become so engrossed in their work that they must be watched carefully for muscle fatigue; not infrequently such fatigue is discovered in the physiotherapy department and the amount of work in the work shop is then cut down. Cooperation between the two departments is thus of vital importance.

When patients have reached their work tolerance they are allowed to rest. Recreation is provided in the form of billiards, horse shoe pitching, darts and the like. These games are also used as a form of recreational therapy, the patient being instructed in the playing of these games to use the injured member so as to hasten the restoration of motion.

Regulations for Patients

All patients who enter the Centre do so voluntarily and only with the consent or recommendation of their attending physician. There is no direct control over the patients, in that they may accept or reject treatment at the Centre, or discontinue treatment if they so desire. If, in the course of treatment, further surgery becomes indicated, the case is referred back to the attending physician.

The patients report daily and are expected to spend the greater part of the day at the Centre. Hotel accommodations are provided for the out of town cases and transportation is furnished the local cases who cannot travel by street car. Dinner is provided in a nearby restaurant for all patients.

Study of Cases Admitted

Since the opening of the Centre four months ago sixty-eight cases have been examined for admission. One case refused treatment. Four cases needed surgery before treatment could be started and were referred back to the attending physician. Of the sixty-three cases admitted, twenty-three have been discharged. Six have been temporarily discharged for further surgery, two for resection of neuromata, one for plastic repair of the palm of the hand, and three for sympathectomy to relieve reflex vascular spasm. At present there are thirty-four cases receiving active treatment.

Of the sixty-three patients admitted there were ten female and fifty-three male patients. The average age of the female patients was thirty-seven years, that of the male patients forty-seven years. The average length of time from the date of accident to the date of admission was seven months.

Table one shows the ages of the discharged patients by decades. It can be seen that almost one-half of our cases had passed the fiftieth year.

Table I

Age:						
17-20	20-30	30-40	40-50	50-60	60-70	70-80
1	4	4	3	5	5	1

Table II gives a brief resumé of the history, progress, and end results of the discharged cases. There were, then, fourteen cases capable of returning to their original work. Ten patients returned to their regular work. Most of these had serious injuries. One returned to a better position at better pay. One was inducted into the Army following an amputation and multiple compound fractures of the fingers. Two patients were admittedly capable of returning to work. One, a sixty-nine year old machinist, was financially able and wished to retire from work. The remaining patient, a married woman, was doing war work and did not wish to return.

Three cases returned to light work, all of whom had serious injuries. Two of these still showed some limitation of motion following multiple frac-

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Table II

File No.	Age	Sex	Months Since Accident	Diagnosis and Treatment Before Admission	Mental Attitude on		Days in Clinic	Physical Condition on Discharge	Work When	
					Admission	Discharge			Injured	Discharged
55	32	F	3	Trigger thumb—Resection of sheath	Normal	Normal	11	Normal	Machine operator	Does not intend to return to work
40	26	M	17	Compound avulsion of tendo Achilles	Normal	Normal	9	Unimproved	Tractor spreader	Did not stay for treatment
37	65	F	3	Trigger thumb—Resection of sheath	Normal	Normal	42	Normal	Candy packer	Same position
30	62	M	13	Old Fracture of humerus. Radial and median nerve paralysis. Septic wrist joint.	Depressed, belligerent	Same	54	Slight improvement in hand	Quarry worker	Did not continue treatment
25	29	M	1½	Amputation of both phalanges of thumb.	Depressed	Normal	21	Excellent grip	Lathe operator	Same position
22	61	M	7	Dislocation of shoulder. Rupture of supra-spinatus tendon—sutured	Depressed	Normal	72	Normal motion and strength	Gas station operator	Same position
20	62	M	1½	Colles fracture, left. Old fracture of left scaphoid. Marked limitation of motion.	Normal	Normal	52	Improved	Tube packer	Light work
19	20	M	8	Compound fractures of second, third, fourth and fifth fingers. Laceration of extensor tendons of second, third and fourth fingers. Amputation of distal two phalanges of midfinger.	Normal	Normal	12	Marked improvement	Spreader	Inducted into Army
16	17	M	7	Fracture of humerus. Radial nerve palsy. Open reduction.	Normal	Normal	55	Normal motion, slight residual palsy	Spreader	Same position
14	73	M	4	Colles fracture in malposition. Old arthritis of hands. Loss of shoulder motion.	Normal	Normal	98	Slight loss of shoulder and finger motions	Dishwasher	Same position
11	30	M	7	Fracture of right humerus, radius and ulna. Much muscle atrophy,	Normal	Normal	17	Improvement in motion	Wire painter	Light work
10	35	M	6	Fracture of fifth metatarsal. Normal motion. Persisted in using cane.	Apprehensive	Normal	9	As on admission	Elevator operator	Better pay and work
7	69	M	7	Colles fracture in malposition. Loss of motion in wrist and shoulder.	Normal	Normal	100	Improvement in shoulder and wrist motion	Machinist	Did not wish to return to work
6	42	M	11	Chronic bursitis of right shoulder. Motion nearly normal.	Very apprehensive	Normal	9	Shoulder motion normal	Core driller	Same position
5	55	M	8	Compression fracture of twelfth dorsal vertebra. Bilateral thrombosis of femoral veins. Arthritis of spine. Ligation of veins. Cast.	Normal	Normal	97	Marked improvement	Floor hand	Light work
4	58	M	4	Colles fracture, left. Fracture of external malleolus. Marked loss of wrist, forearm and shoulder motion.	Normal	Normal	96	Normal motions in all joints	Porter	Same position
42	50	M	2	Amputation of one and one-half phalanges of left mid-finger.	Normal	Normal	37	Normal motions in all joints	Stock fitter	Same position
27	42	M	6	Fracture of head of left radius—cast	Normal	Normal	5	Five degree loss of motion	Newspaper circulation	Same position
32	31	M	3	Bimalleolar fracture of ankle	Normal	Normal	12	Ankle motion nearly normal	Brewery worker	Same position
28	46	M	6	Bilateral fracture of oscalcis	Normal	Normal	27	Loss of subastragular motion	Electrician	Has not returned to work
53	53	M	2	Intercondylar fracture of proximal phalanx of index finger into joint with displacement. Old amputation of middle and ring fingers.	Normal	Normal	60	Still has loss of motion	Molding machine operator	Has not returned to work
38	59	M	6	Fracture of both bones of leg	Normal	...	...	Developed intestinal obstruction due to cancer. Died.		
45	57	M	12	Amputation of right ring finger. Loss of motion in wrist, elbow and shoulder.	Extremely neurotic	Same	13	Unimproved	Helper	Has not returned to work

tures. Two cases have been discharged from the Clinic with permanent loss of motion. One, an electrician, shows loss of subastragular motion following bilateral fractures of the oscalcis. The other, a molding machine operator, had previously lost two fingers and received a compound fracture of the proximal phalanx of the index finger into the joint, with displacement, and resultant loss of flexion of this finger. Neither could be further benefited by treatment and neither has returned to work.

Three discontinued treatment voluntarily, one because he did not wish to remain in Boston away from his family. The second was a psychoneurotic whose resultant loss of motion of the entire upper extremity was out of proportion to the original accident, an amputation of a ring finger. The third was a depressed, belligerent man with a badly crippled hand, who had received rather poor surgical treatment prior to admission; he was unable to get along with the personnel of the Centre or with his fellow patients.

The last patient developed intestinal obstruction from a carcinoma and died.

The average length of stay at the Centre for discharged cases was six and one-half weeks in the improved cases, and four and one-half weeks in the unimproved cases.

Results Have Been Successful

It may be seen from the above that our results have been quite successful, especially when one considers that the Centre has been functioning only four months, and also that most of our cases have been in the upper age bracket, with an average duration of time elapsed from accident to admission to the Centre a period of seven months Much more impressive results can be obtained when cases are seen in their early stages, before muscle atrophy, joint fixation and neurosis or depression have been allowed to develop.

There are thirty-four cases now under active treatment. The various diagnoses are as follows:

Diagnoses	*No. of Cases*
Chronic subdeltoid bursitis	6
Ruptured disc (operated with spinal fusion)	4
Fractures of a single extremity	5
Multiple fractures	5
Multiple amputations	4
Compression fracture of spine	2
Severe sprains	2
Wringer hand	1
Stenosing tenosynovitis	2
Deranged knee cartilage	1
Hypertrophic arthritis of knee, spine, hip	2

The average age of the thirty-four patients, whose diagnoses appear above, is 47 years, and the average length of time from the date of their accident to the date of treatment at the Centre is seven months. Seven of the patients are now nearly ready to return to work. Four others will eventually need surgery. In all probability nine of the cases will have some residual loss of motion of which five, including two extensive amputations, will be unable to return to their regular work.

The above gives some idea of the type of cases treated and the results obtained to date at the Rehabilitation Centre. Our cases are not hand picked and any case which might be benefited is admitted for treatment.

In all of the above cases the diagnosis has been definite. No such diagnosis can be made in the acute back strain, and consequently none of these cases have been admitted as yet. However, in the near future we intend to attempt treatment of this condition.

The idea of rehabilitation of the injured workman is relatively new. Much has yet to be learned in the proper handling of these cases, particularly from the point of view of work therapy. However, though the Rehabilitation Centre is still in the experimental stage, we feel that it is of definite value.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACTS OF CONGRESS OF AUGUST 24, 1912, AND MARCH 3, 1933

of *Rhode Island Medical Journal*, published monthly at Providence, Rhode Island, for October, 1943.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Act of March 3, 1933, embodied in section 537, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street; Managing Editor, John E. Farrell, 106 Francis Street, Providence, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock bonds, or other securities than as so stated by him.

PETER PINEO CHASE, M.D., *Editor-in-Chief*

Sworn to and subscribed before me this 14th day of October, 1943.

JOHN E. FARRELL

(My commission expires June 30, 1946.)

[SEAL.]

EMERGENCY MATERNITY AND INFANT CARE PROGRAM

Final report *of the Special Committee Authorized by the Council of the R. I. Medical Society to Study the Federal Emergency Maternity and Infant Care Program for Rhode Island. This report has been received and approved by the Council.*

At its September meeting, the Council of the Rhode Island Medical Society authorized the Chairman of the Committee on Maternal Health to appoint a committee to consult with Dr. Francis V. Corrigan (Medical Director of the Division of Maternal and Child Health of the Rhode Island Department of Health) in formulating a plan to put into effect the Emergency Maternity and Infant Care Program authorized by Congress under the Children's Bureau. The following physicians consented to serve on this committee:

Dr. John Helfrich, Westerly
Dr. Alfred Potter, Providence
Dr. John G. Walsh, Providence
Dr. Henri Gauthier, Woonsocket
Dr. John Kenney, Pawtucket
Dr. George Young, East Greenwich
Dr. Henry Utter, Providence
Dr. Wm. P. Buffum, Providence
Dr. James Callahan, Newport
Dr. E. S. Brackett, Providence, Chairman

The program in its essential features has been outlined by the Federal Bureau and forwarded to the Department of Health of the various states leaving to the States only administrative details such as the eligibility of hospitals, the agencies through which applications for benefits may be made, etc.

The Federal program contemplates (1) the payment of stipulated sums to hospitals and (2) payment of stipulated fees directly to physicians for maternity care to mothers and pediatric care to children under one year of age of men in the armed services. The program in brief outline is as follows:

Eligibility. The wives and children (under one year of age) of service men in the four lowest pay grades of the Army and corresponding grades in the Navy (including the Coast Guard and Marines) are eligible to receive benefits under this program. These four grades include all grades up to and including sergeants. The families of sergeants above the fourth pay grade are not eligible as their pay is often equal or more than that of some of the commissioned officers. In determining the eligibility of applicants for benefits no consideration is given to the financial status of the applicant.

Hospital Care. The State Board of Health, from funds made available by the Federal Children's Bureau under this program, will pay directly to hospitals their bills for ward care of eligible patients at a per diem equal to the per diem cost to the hospital. The patient must become a ward private or ward patient. She may not apply her government allowance as part payment for semi-private or private room service. If she chooses to be a semi-private or private patient she forfeits her right to a government allowance.

Eligibility. All hospitals in the state approved by the American College of Surgeons are eligible. No salaried employee of the hospital may receive any remuneration for medical care of a ward patient, such medical care being considered a part of the hospital service.

Medical Care. The Federal Government through the State Department of Health will pay specified sums directly to physicians for Maternity Care and Pediatric Care to wives and children under one year of age of service men in the four lowest grades. The physician accepting a patient under this plan must sign a statement that he will not accept any further payment for the care and the patient must pledge herself not to pay any fee in addition to the fee paid directly to the physician by the government. The physician accepting a patient under this program may not charge, or the patient pay, any additional fee for obstetrical or surgical operations or for the treatment of obstetrical or medical complications during pregnancy, labor or the puerperium. Provision is made for necessary consultations. The fee is all inclusive for obstetrical service for the period of her pregnancy, labor and puerperium (six weeks).

Similarly specified allowances are provided for pediatric care.

The patient may choose her own physician. Under the plan as proposed for the State of Rhode Island any registered physician who is a graduate of a Class A medical school is eligible to receive payment from the Federal fund.

A patient may choose to be delivered in her home. Provision is then made to pay the usual charge of a visiting nurse in addition to the payment to the doctor.

If she arranges to be delivered in a hospital her hospital bill as a ward patient will be paid and a stipulated sum may be paid to her physician for complete obstetrical care including antepartum visits, labor and postpartum care up to six weeks. As previously stated, if the patient chooses to enter the hospital as a semi-private or private patient she forfeits her right to have her hospital and physician's bills paid under this program.

The patient may choose any physician who has the privilege of practicing obstetrics or pediatrics in the hospital of her choice.

First Meeting of Committee

The first meeting of the committee was held September 29. Doctor Corrigan submitted a Rhode Island plan which, if approved by the Society, he proposed to submit to the Federal Children's Bureau for approval. After an explanation of the plan by Dr. Corrigan and a frank discussion of the plan by the committee the following conclusions were reached.

The committee recommended (1) approval by the Society of the objective of the plan. It was the sense of the committee that the government having taken into service to fight for our country the breadwinners of the family, it is under a moral obligation to provide for their families all the necessities of life, maternity and pediatric care being among them. (2) Approval by the Society of the payment directly to hospitals of the cost to hospitals of providing ward care for maternity and pediatric cases in the families of men in the armed services. (3) Approval, in principle, of the government making allowances under the proposed plan for medical care of maternity and pediatric cases. The committee believes that whether this program is put into effect or not, no wives or children of men in service need ever suffer in Rhode Island for lack of adequate medical service no matter how needy they might be. This has been true in peace times and certainly in these times of emergency the medical profession would not be likely to abandon all its honorable traditions of service to rich and poor alike.

The committee had several objections to the manner in which the proposed relief must be administered. These objections will be discussed later. The committee also criticised the plan as submitted because it failed to provide in adequate measure for medical and surgical consultations and treatment for intercurrent conditions which might need the specific knowledge and skill which only a specialist could possess.

Dr. Corrigan was requested to formulate a plan to meet the objections of the committee. This he did and submitted it to officials of the Children's Bureau who, very tactfully, made it quite plain, unofficially, that any plan that modified the benefits as prescribed by Congress would not be accepted.

Participation by Doctor Voluntary

At the second meeting of the committee on November 3rd, Dr. Corrigan submitted a third plan, already outlined, in regard to which the committee has the following observations to offer.

While it is opposed to many provisions of the plan it does not feel that the society should withhold its co-operation. No group in war time is justified in adopting an uncompromising attitude toward government measures. It believes the society should not make any recommendations as to the attitude of the individual members toward accepting a fixed fee paid to them directly by the government, but if they do accept such a fee the society would severely condemn any attempt on their part to circumvent the conditions under which the fee was accepted. It does not feel that any member is under any moral obligation to accept cases under this program. The refusal of an individual member to accept these cases would not cause any woman or child in Rhode Island to suffer from lack of adequate medical care. The patient is still at liberty to employ another doctor or to be treated in a hospital as a ward patient.

Objections Voiced by Committee

The committee feels that, having approved in principle the objective of this plan and having recommended that the medical profession co-operate in carrying it into execution, it should state its objections to some of its provisions.

It objects to what it considers too rigid bureaucratic control of funds allocated to the various states by the Federal Children's Bureau. State Departments of Health should be given a freer hand in adapting their methods to the needs of the territories which they serve.

continued on next page

It objects to the payment of funds directly to the doctor rather than to the patient to be spent at her discretion. The allowances for the support of the wives and children of service men are not hedged about by any such restrictions. Undoubtedly an occasional improvident patient would spend the allowance unwisely and her doctor's bill would not be paid, but it is no new experience for a doctor to have unpaid bills on his books. In any case, the doctor would be the only loser, for in Rhode Island no improvident patient need ever suffer for lack of maternity care or pediatric care for her baby. Lack of faith in people whom they are supposed to serve is characteristic of bureaucrats. The threat of financial loss to the medical profession is insignificant compared to the threat to the profession and public of bureaucratic control of the private practice of medicine implicit in these unnecessary restrictions.

It objects to the provision that limits allowances to ward patients. It does not consider the allowances under this program as a charity dole to the medically indigent but as a discharge of a moral obligation on a par with army pay and allowances for the support of the wives and children of service men. It can see no valid reason why, if a patient can afford to do so, she should not be allowed to add a few dollars to the government payment to the hospital and occupy a semi-private or private room. She could do so if she were a member of the Blue Cross or were insured in a commercial insurance company. This is another example of the bureaucratic control of medical practice.

It has the same objection to the provision which prevents a patient from coming to a financial arrangement mutually satisfactory to her and the physician of her choice, and compels her to promise that she will pay her physician no fee in addition to the government allowance and the physician to pledge himself not to accept any additional fee. It objects to the inflexible, government-dictated, fixed fee—a form of price fixing which even in the present emergency is unnecessary. The committee has no quarrel with the amount of the fee. Taking into account the government guarantee of payment in full and the fact that many patients who would benefit by the program would otherwise be unable to pay a doctor anything at all, it is not unlikely that the medical profession would profit financially by this arrangement. It should not without protest exchange its right to deal directly with its patients for a temporary financial advantage and further bureaucratic control of the practice of medicine. The committee believes that the government allowance should be paid directly to the patient and she should be free to make her own financial arrangements with the doctor of her choice.

Program Fraught With Political Implications

If the committee felt any assurance that this program was, as its name implies, merely an emergency measure and would be discontinued after the war, it might accept its objectionable features without protest as part of the economic dislocation inevitable in war time. But it has, it believes, good ground to fear that it is, over and above its immediate humanitarian objective, another move by a group of professional uplifters toward their ultimate goal of complete domination of the practice of medicine by the Federal Government. The more the practice of medicine is controlled by government the deeper it will get into politics. Control by government means control by politicians and bureaucrats. Cancer and tuberculosis and heart disease do not select their victims because of their political affiliations. A sick politician seldom chooses his physician because of his political faith, but too often when a salaried medical appointment is to be made the first question asked is not who is the best available man for the job, but who is the most available Republican or the most available Democrat, and the man who has the most powerful friends gets the job. However high-minded the political leaders at any particular time may be and however fortunate their appointments, in the long run the system inevitably tends to lower the standard of medical practice. The deeper the private practice of medicine becomes involved with government, the more rapid will be that deterioration. In no country in the world is the private practice of medicine more efficient than in America. This efficiency is in large measure due to the fact that government, heretofore, has in the main confined itself to its proper sphere (sanitary codes, drug control, sanitaria and hospitals for the indigent and the like) and has kept its hands off the private practice of medicine.

It is government interference in the relation between the physician and his private patient in the program under consideration which alarms the medical profession for it is convinced that government interference can have but one result—less efficient care of the sick.

MEDICAL AND SURGICAL TREATMENT OF VARICOSE VEINS, PULMONARY EMBOLI, AND GASTRIC AND DUODENAL ULCER

A SUMMARY *by Anthony V. Migliaccio, M.D., Associate Surgeon, R. I. Hospital, of the Discussions at the November Meeting of the Providence Medical Association by Arthur W. Allen, M.D., Chief of East Surgical Service, and William B. Breed, M.D., Visiting Physician, Massachusetts General Hospital.*

ON Monday, November 1, 1943, Dr. Arthur Allen, Surgical Chief at the Massachusetts General Hospital and Dr. William B. Breed, associate in medicine at the same hospital, provided us with a lot of food for thought in a question and answer program covering the subject of varicose veins, pulmonary emboli and the perennial problem of ulcer, both gastric and duodenal. It was brought out that the injection treatment of varicose veins at the Massachusetts General Outpatient provided an 80% failure. Because of this, dividing the great saphenous vein and its branches was tried with better results. This latter procedure was supplemented with injections at the time of the operation, but in their experience the sclerosing fluid rarely went beyond the lower thigh. Dr. Allen admitted that he had had no experience with the use of injecting fluid through a urethral catheter which had been inserted into the great saphenous and pushed down to the midthigh.

Because of the failure with his method of getting sclerosis below the knee, Dr. Allen has gone back in many cases to a stripping operation which is somewhat modified from the old technique. It was his opinion that sympathectomy was indicated in some of the cases of leg ulcers which had failed to respond to ligation and injection treatment, but he felt that sympathectomy for this condition is being done more often than it should be. On the question of varicose veins following phlebitis, it was felt that if after six months the deep circulation could be found not to be blocked that then ligation of the superficial veins could be carried out.

Dr. Breed felt that the use of heparin and dicouramin in the treatment of emboli was not all that it was supposed to be. He felt that the three or four day lag period which was present in the use of these drugs was of definite disadvantage. At the Massachusetts General it is customary for the medical man to tell the surgeon to ligate the femoral veins immediately whenever a diagnosis of pulmonary embolus has been made. It was Dr. Allen's opinion that the ligation of the femoral veins was a distinct improvement over the old methods of treating emboli. The diagnosis was suspected as soon as any patient showed a slight rise in temperature, pulse and respirations, and as soon as these changes were observed a close and careful study was made, and if it was felt that a thrombus existed, ligation was immediately carried out. This operation has not only improved the mortality figures but it has also shortened considerably the hospital stay of these patients. Following the ligation of the femoral vein it was the experience of the Massachusetts General group that even though the embolus extended beyond the point of ligature and could not be removed by the usual methods that not a single case of fatal emboli following ligation had occurred. The average hospital stay is approximately five to eight days and it is not unusual for patients to get out of bed on the day following operation.

During the discussion of peptic ulcers it was interesting to note the unusual amount of cooperation and coordination that existed between the medical and surgical consultants. Dr. Breed said that the audience would probably think that he was Dr. Allen's assistant from the way he spoke about the treatment. This was an interesting innovation especially to those surgeons in the audience who felt that the medical man in the past had been too slow in advocating surgery in his ulcer patients. He brought out the fact that close cooperation and immediate consultation with the surgeon is essential if the treatment of ulcer is to be improved.

The young patient with a bleeding ulcer can be treated medically with an extremely high percent of success. In the older patients, the decision of whether to treat surgically or medically is extremely difficult. If surgery is to be undertaken at all in a patient beyond 45, it should be carried out within the first 72 hours. After 72 hours the mortality rate makes it too hazardous to undertake. Location of the site of bleeding must be definitely

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WARTIME CIVILIAN MEDICAL CARE

Report *of Committee on Problems Due to the Shortage of Physicians. Elihu S. Wing, M.D., Chairman, Charles J. Ashworth, M.D., and Alfred L. Potter, M.D.*

With more than one fourth of all the medical doctors of Rhode Island in the armed forces, and more soon to enlist, the problem of civilian medical care is an extremely important one. There has been much concern expressed in some parts of the State relative to the availability of doctors to provide adequately for the protection of health on the home front.

Any discussion of the civilian medical care problem must be prefaced by a clear understanding of the fact that medical service for the armed forces is a priority that takes precedence over all other requirements. It is the one service for which there can be little or no compromise. We all expect, and even demand, that our men fighting on the war fronts all over the world shall have the benefits of the finest medical care available. The doctors of America have responded willingly to the call for military duty and at the present time there are approximately 50,000 of them in active service, in every land where American soldiers are stationed.

The voluntary enlistment by doctors from the very onset of the war probably affected the amount of medical service available in some parts of the country, but with the establishment of the national Procurement and Assignment Service under the War Manpower Commission, with a medical committee in each State, every effort has been made to balance the needs of the armed forces with the minimum requirements of the civilian population. Through this agency every doctor has been classified, not only as regards his age but more particularly as to whether he can be replaced in the community, or whether older doctors can absorb the additional work created by his enlistment.

With the war areas continuing to expand, and with battle engagements becoming increasingly more intense, the need for additional medical personnel by the armed forces is self evident to any citizen. This additional drain upon the roster of doctors still in civil practice is certain to be a cause for concern and even worry relative to the protection of civilian health. It is time that everyone recognize the seriousness of the situation and make every effort to safeguard his personal good health during the months ahead.

Medical care will continue to be available for the civilian population. However there is every reason to believe that in the winter ahead such care will be limited by factors beyond the control of all of us at the present time. Emergency and essential medical care for all who require it will be available, but additional service will depend in no small measure upon the physical ability of the doctors, many of whom are advanced in years, to meet the demands.

The situation in Rhode Island has been repeatedly checked by the Procurement and Assignment Service, the U. S. Public Health Service, and by the special committee of the Rhode Island Medical Society to study the problems resulting from a possible shortage of doctors. The number of medical doctors in the State, exclusive of those employed as full time staff members of hospitals and institutions, totals 626 in active practice, according to the best figures available to our committee. Of this number 398 range in age from 45 to more than 80 years, while 223 are aged up to 45 years. Many of the later group are now listed as available for military duty and will undoubtedly volunteer with the armed forces in the near future.

Nationally there have been statements to the effect that the ratio of one doctor to every 1500 population is a safe one for the protection of civilian health. If such a yardstick were applied to Rhode Island today we would be more than adequately protected, with an average on the present figures of one doctor to approximately every 1140 persons.

However, there are many reasons why this statistical gauge may, in part, be disregarded here. In the first place the 626 doctors in active practice include 115 who are certified specialists in particular phases of medicine and surgery, and therefore they must be considered as available for limited fields of work only, although, no doubt, in an emergency they would be ready to do general practice. Remov-

ing this group from our total would still give us a presumably safe average of one doctor in general practice to every 1400 persons in the State.

But even this figure cannot be taken at face value, for the distribution of doctors is not comparable to the distribution of the entire population. Thus we can strike an average of one doctor to every 1000 persons in the city of Providence, one to every 2600 persons in East Providence, and Cranston, one to every 1400 in Pawtucket, and one to every 3600 in Central Falls. Yet there is no real shortage in any of these communities, for their geographical proximity, together with modern rapid transit, has made the doctor in Providence as available to the people of Cranston or East Providence as he is to citizens in parts of Providence. The same situation holds for Pawtucket and Central Falls, and for many other communities of the State that are adjacent to larger cities or towns.

There are other factors, too, which must be considered. The personal choice of the individual in the selection of his physician results in certain doctors carrying more work than some of their colleagues. The age and physical ability of other doctors force them to limit their practice and to eliminate travel as much as possible. The additional strain created by the task of coping with all the demands for medical attention while more than 200 Rhode Island doctors are away on military service has resulted in excessive fatigue and sometimes illness for many doctors, necessitating that they concentrate on emergency and essential needs.

Therefore we cannot say that a numerical ratio is any criterion that everyone is going to get medical attention at any time he may desire it. Rather, we can only assure the people of Rhode Island that the medical profession stands ready to do all in its physical power to meet the necessary requirements of the civilian population during this trying period. There will be times when a doctor cannot be reached promptly. We can only ask that everyone make an earnest effort to safeguard his own personal health at all times, and also that every citizen endeavor to conserve the time and the energy of the doctors that they may be able to cope with emergency and really essential demands.

In January the Civilian War Services of the State Council of Defense will launch its Keep Well Crusade which has the endorsement of the Rhode Island Medical Society. Pamphlets are to be distributed giving suggestions relative to ways to help the doctor during the war emergency, and we are sure that if these suggestions are adopted generally, not only will the physician's burden be eased but the health of the public will be better protected in the difficult days ahead.

DISTRIBUTION OF DOCTORS FOR CIVILIAN CARE

(As of December 1, 1943)

	Total M.D.'s Now In Practice	*Active M.D.'s Age Over 45*	*Age Under 45*	*M.D.'s Not In Practice*
BLACKSTONE VALLEY				
Central Falls	7	5	2	
Lonsdale	1	1		
Pawtucket	55**	33	20	4
Saylesville	1		1	
Valley Falls	1	1		
BRISTOL COUNTY				
Barrington	1	1		1
Bristol	5	2	3	1
Warren	5	4	1	
KENT COUNTY				
East Greenwich	3	2	1	
Lakewood	2	2		
Norwood	1		1	
Warwick	5	2	3	1
West Warwick	14	7	7	
NEWPORT COUNTY				
Adamsville	2	2		
Block Island	1	1		
Jamestown	1		1	
Little Compton	2	2		2
Newport (City)	24	14	10	3
PROVIDENCE AREA				
Cranston	18**	10	7	2
East Providence	12	7	5	
Providence (City)	371	245	126	10
Rural	11	7	4	1
WASHINGTON COUNTY				
Rural	18	10	8	2
Westerly	19*	14	5	
WOONSOCKET DISTRICT				
Harrisville	1	1		
Pascoag	3	3		
Manville	2	2		
Slatersville	1		1	
Wallum Lake	2	1	1	
Woonsocket (City)	37**	19	16	1
TOTALS	626***	398	223	28

*Age of one doctor not known.
**Age of two doctors not known.
***Includes 5 doctors—age unknown.

VARICOSE VEINS, PULMONARY EMBOLI, Gastric and Duodenal Ulcer

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established even if a fluoroscopic examination must be undertaken before surgery is considered. Once it has been decided that the bleeding is from an ulcer and that surgery is necessary, then gastric resection is the procedure of choice. The blood pressure should be above 100 before surgery is undertaken. In a patient in whom a vessel has been eroded by the ulcer, recovery from transfusion is less likely to occur. Multiple transfusions are necessary both in the medical and surgical treatment of the bleeding ulcer. In those cases where bleeding stops, Dr. Breed believes in feeding them as soon as the patient is hungry. Dr. Breed is also of the opinion that a middle course between starvation and the Mullengrath treatment is the proper course in the treatment of bleeding ulcers. Antacids in ulcers are not good, bicarbonate should not be used, aluminum should be used only for emergency rations and the time table in feeding is much more important than the type of food.

The treatment of gastric ulcer is definitely one of surgery. Fourteen percent of the resected cases invariably show Ca. and here the medical treatment is not as successful as it is of duodenal ulcer. More over, gastrectomy in the presence of gastric ulcer is much safer than it is in cases of duodenal ulcer, as in these cases the duodenum is perfectly normal. It is the poor closure of the diseased duodenal stump that causes 50 percent of the postoperative trouble in gastrectomies. The patient with duodenal ulcer should be submitted to surgery in all acute conditaions, such as perforation. He should also be submitted to surgery whenever he has become tired of his pain and when the medical treatment has failed after several honest attempts at cure. Gastroenterostomy should never be performed except in the presence of complications. Gastrectomy is by far the best treatment that we have today for ulcer. The incidence of ulcers of the stoma following this operation is less than 1%. Dr. Allen even refuses to do a gastroenterostomy in the old patient with obstruction and low acidity because in his experience the results have been very poor, whereas, gastrectomy has always proved satisfactory.

Dr. Allen prefers to use a posterior short-loop Hoffmeister type of operation. The anticolic is rarely used on his service. He claims that the anticolic is easier to perform, that it takes less time but that it is much more apt to get into trouble because of the chances of adhesions of the anastomosis to the undersurface of the abdominal scar. He also believes that there is more malfunction in the anticolic group than in the posterior type.

Dr. Allen has drained the duodenal stump in approximately 20 cases but he feels that it is unnecessary. He also prefers to use No. 30 cotton for suturing and No. 60 cotton for ties.

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The RHODE ISLAND MEDICAL JOURNAL

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THE CURATIVE CENTRE

The General Assembly at its last session enacted legislation establishing a special curative centre fund the purposes of which are stated in the law as follows:

"To provide a suitable structure for the housing of the curative centre."

"To furnish said structure with necessary equipment for the rendering of physical therapy, psychotherapy, and occupational therapy."

"To provide for the payment of all salaries of personnel necessary for the operation of the centre."

"To provide funds to pay all other expenses for the carrying out of the above purposes. The director of labor shall purchase all necessary equipment . . . after consultation with the medical director and with the advice, consent and approval of the advisory board."

The Advisory Board provided in the law is to consist of the director of labor, the chief of the division of workmen's compensation and three medical men to be appointed by the director of labor WITH THE ADVICE AND CONSENT OF THE COUNCIL OF THE RHODE ISLAND MEDICAL SOCIETY.

Here is the status of this program as it appears to us today, some seven months after the Governor signed the act to make it the law.

The Medical Advisory Board has not been appointed, and no names of medical men have been submitted to the Council of the Rhode Island Medical Society. The medical director, the key man in the entire program, as Dr. Aitken has so pointedly indicated in the article in this issue relative to the Rehabilitation Centre of the Liberty Mutual Insurance Company in Boston, has yet to be recommended to the Council of the Rhode Island Medical Society whose advice, consent and approval is required by law prior to his appointment.

But approximately three-fourths of the fund accumulated this year has already been expended for a 35-room residence, leaving, according to the latest public announcement, less than $14,000 with which to purchase equipment, hire medical, technical and clerical personnel, and meet the ordinary expenses of building maintenance! It is reported that the State has already taken steps to get priorities for the purchase of equipment, a step that undoubetdly is necessary in these days of limited production, but it is interesting to note that the law states that purchases of equipment are to be made *after* consultation with the medical director and with the advice, consent and approval of the advisory board. Before seeking priorities it would appear advisable to determine exactly what equipment is to be approved for purchase.

The public announcement of the purchase of the estate to house the Curative Centre also contained alleged statements that the residence would be furnished with the equipment of the individual tradesmen who will use the centre, and will cover all branches of the building trades. The statement was also made that it was estimated that from 40 to 50 patients a day would be treated once the centre is established, and the handling of up to 100 cases a day could be effected by the purchase of additional equipment.

After reading the excellent study of the Boston rehabilitation center in this issue of the JOURNAL, and after a visit to that centre, we are a bit confused as to the program of rehabilitation work the local authorities indicate for the curative centre here. We sincerely doubt that individual equipment is either necessary, or possible, to cover all branches of the building trades. Rather we believe the centre is to aim at the fundamental basic physical and occupational activities, such as are already carried on at the Rhode Island Hospital and at the Bureau for the Handicapped, as the means to speed the return of the patient to work, and preferably to his own occupation. When we note that the centre established by the Liberty Mutual Insurance Company is available to far more workers throughout New England than there are in our State alone, and that in four month's time only 64 cases were admitted for treatment and only 34 are now in attendance, we are completely at a loss to understand the 40 to 50 patients *a day* expected at the Rhode Island Curative Centre when it is opened.

The medical profession of Rhode Island has always been willing to assist in any program which will aid in the restoration of good health to the sick and the injured. It desires that the Centre be given full opportunity to prove its value to the industrial workers of the State, but it recognizes that the success of the program hinges far more on the medical and technical supervision of the patients than on the location of the building wherein the treatment is to be given. There should be no further delay in the appointment of the medical director and the advisory board.

THE DOCTOR SHORTAGE

Our country needs immediately more doctors for the armed services, as casualties on the war front are increasing rapidly. The 50,000 doctors in service (nearly a third of the country's physicians) are scattered all over the world. There are in this country 600 Service Hospitals, including scores of over 1000 beds, occupied in part by service men from overseas.

Rhode Island has a doctor shortage—as do most States of the Union—though we are amongst the more fortunate, since our small size and compact population give better access to medical care than is the case in the larger States.

Where would our privileged American life now be with its great institutions and high ideals had not thousands of our doctors and civilians volunteered for its protection? These men and women have left their jobs, homes and families, and are risking life and health that America may continue to enjoy the privilege of religious liberty and the pursuit of happiness. Surely our patriotism must equal theirs.

With this urgent need existing by the military forces for more doctors many, especially in the towns and cities, are still classified as "A"—available. Whereas withdrawal of these men from their home communities entails sacrifice both by themselves and the civilian population, it is a sacrifice which all should freely offer in so sacred and just a cause.

Our citizens, most of whom now have near and dear ones in the service, may of right ask that their boys' health and well-being be properly cared for, an impossibility except with sufficient medical personnel. These same citizens will place "the boys" first, "themselves" last, in this matter of proper care.

The recent Procurement and Assignment meeting under the auspices of the Rhode Island Medical Society, and the attendant interviews with a majority of those still available, proved that a considerable number volunteered to apply for a commission, while others declared they would probably do so. The P and A Service, which constantly emphasizes its function as a body to encourage "voluntary" offers of service, is inclined to believe that further such offers will follow immediately. The need is not next year, but today.

In 1942 the Rhode Island quota for doctors was met exactly 100%. In 1943 the quota is far short of completion.

Patriotism led those into service in 1942. A like patriotism, we hope, will lead others to volunteer until the 1943 quota is filled.

IT'S YOUR JOURNAL

With this issue the RHODE ISLAND MEDICAL JOURNAL completes its twenty-sixth volume. The occasion takes on added significance in view of the

recent expansion which has warranted much favorable comment, and which presages a future development that will go far towards making it one of the outstanding journals.

By national authorities your JOURNAL has been characterized as the finest medical publication from the viewpoint of typography and format. That the contents are far above the average is fully evidenced by the fact that they have been subject to reprint and review in other publications. For example, the excellent paper by Dr. Place which appeared in the August issue has been summarized and published in *The Trained Nurse and Hospital Review;* the article on "The Luxury of Social Insurance" in the September issue has been widely publicized by insurance groups, and has recently been reprinted in *The Weekly Underwriter,* one of the leading insurance publications with national distribution; and the exceptionally fine report on "Burns" in the October issue has been reprinted by the National Fire Protection Association for nationwide reading.

Some of the editorials have been copied in other medical publications, and last month's lead editorial, while misinterpreted in some circles, has provoked an open discussion of the medical aspects of the State sickness insurance program which will go far towards a better evaluation of the plan.

The development of departments within the JOURNAL for the purpose of more fully informing the members of the various activities and problems of the Society has involved much detail work. The assistance of members is sought to further these efforts and to make your JOURNAL the best in the country.

E M I C PROGRAM

Every member of the Society should read carefully the report of the special committee authorized by the Council of the Society to study the emergency maternity and infant care program created by the Federal Children's Bureau of the Labor Department, and administered locally through the Division of Maternal and Child Health of the State Health Department.

The program has been the subject of debate the length of the land. Its adoption by state departments of health has been construed wrongly to constitute complete endorsement by the medical profession of the respective states, whereas in truth the profession has had no say whatever in the shaping of the policies by which the assistance is granted.

In spite of the nobility of the purpose—a purpose which the medical profession by and large was already meeting without placing any additional financial burden on the families of service men—the program is a challenge to every doctor. It places the control of a local plan of medical service under a federal supervision which admits of little alteration to meet local conditions. It denies to the patient a cash allowance to assist her to meet her requirements as she desires, even to the extent of forbidding semi-private or private care in the hospital when such accommodation is within her budget. It sets a fixed fee for the complete care and denies the existence of, and discourages the attempt at, better than ordinary obstetrical service, and it implies the possibility that this program will be the forerunner of other similar projects in the months ahead.

What is not generally known is that the program is not the original creation of Congress acting as the representatives of the people. It stems from the Children's Bureau itself which made $380,000 available by administrative action. The 77th Congress subsequently failed to enact as part of the appropriation bill a $750,000 request of the President, and as a result the Children's Bureau continued to make allotments administratively.

Again, in 1943, when the President asked for $1,200,000 to carry on the EMIC program the House refused because it felt that Congress had never authorized the program in the first place. The Senate amended the appropriation bill, however, to include the amount, and the House finally conceded. This money lasted but three months and a second appropriation of $4,400,000 was made, but that too lasted for only a short time. Last September a supplemental appropriation bill was enacted to provide $18,600,000 to continue the expansion of the work.

If, as the special investigating committee of the Society has pointed out, there was any assurance that this program is as its name implies, merely an emergency measure which will be discontinued after the war, the present objectionable features might be tolerated. But the major issue appears to resolve itself into the question of determining how readily a program that has increased more than fifteenfold in cash expense in less than a year can be not merely curtailed but eliminated at the end of the war period.

THE MEDICAL LIBRARY

The Medical Library is more than a mere storehouse for the records of a great profession. It is

probably the most important single service offered to the Profession, for its rich materials constitute a treasure that offers unlimited possibilities to the physician who knows how to make full use of it.

Many of our members undoubtedly have little idea of the help and guidance that is available through our exceptional staff of Miss Dickerman and Miss Moffitt whose long experience in medical library work assures the busy doctor aid that can readily be valued in terms of accuracy and time. The thought and labor involved in making available on short notice to any member the latest data on any medical subject is probably never realized or fully understood by the doctor.

Every new book acquired, by purchase or gift, is carefully examined and indexed before it takes its place on the shelves with the more than 35,000 volumes now stored at the Library. More than 150 medical journals are collated each month, and the outstanding ones are bound for permanent file. All publications are indexed promptly in order to make available the newest material on any subject on short notice.

Thus, when a doctor cannot spare the time to do his own searching for materials on the problems which interest him, a telephone call to the Library results in complete reference service. All available literature on the particular subject is surveyed and books and articles are selected and marked for his ready reference. Thereby his time and energy are conserved when he arrives at the Library.

For members who are outside the city, and also for the medical personnel at the military installations in the State, the Library offers a liberal mailing service. Requests directed to the librarian receive prompt attention, and each month now the JOURNAL publishes the newest volumes added to the files.

The Medical Library, exclusively owned and maintained by the medical profession of Rhode Island, is one of the finest libraries in the country. It is capable of many services to the individual doctor. Are you utilizing its facilities to the fullest advantage?

CANCER PREVENTION CLINICS

We are told that doctors in China are paid for keeping their patients well and not for treating them when sick.

The custom has considerable merit, in so far at least as it forces the Doctor to be on the lookout for those early symptoms that treated promptly may prevent the development of serious illness.

Our own people are so prone to adopt a laissez faire attitude until forced by evident symptoms to seek relief that the Chinese practice could never be popular here. But we are beginning to approximate it by urging upon our public the wisdom of annual or even semi-annual health examinations.

This is particularly true in the field of cancer where the American Society for the Control of Cancer asks the members of its Women's Field Army to be examined thoroughly at least once a year. Now we want to widen the field of these examinations by establishing what are known as "Cancer Prevention Clinics."

One of the last official acts of our late beloved President, Dr. Charles F. Gormly, was to ask the approval of the members of the Rhode Island Medical Society for the establishment of such Clinics in our midst.

Since this approval was given, a few words explaining what they are and what they are expected to accomplish may not be amiss.

The idea seems to have originated with Dr. Catherine Macfarlane of Philadelphia who established the first "Cancer Prevention Clinic" in 1938. Twelve hundred enrolled at the start but only 955 have continued for this five year period.

The establishment of this first Clinic has been followed by that of two others, one in New York, the Strang Cancer Prevention Clinic, housed in the Memorial Hospital, and more recently one organized by the Chicago Cancer Committee. These are essentially free Clinics, although those who are able pay five (5) dollars on admission to the Clinic.

The first examination includes a Wasserman, a blood count, the usual routine of heart, lungs, breasts, abdomen, pelvis and rectum and any special examination deemed necessary. If any symptoms of any disease are found the patient is referred to her own Doctor if she has one, otherwise she is sent to the proper Clinic in some hospital. Examinations are repeated twice a year and careful records are kept of all findings.

The three Clinics so far established are for women only, but the wisdom of enlarging their scope to include men is perfectly apparent. Perhaps the name might be changed to "Disease Prevention Clinic".

It is easy to visualize the amount of valuable medical statistics that would be accumulated if several such Clinics could be formed in various parts of the State.

To be successful the Clinics must have the cooperation of our medical men. On the other hand

there is no doubt that the Clinics will be a distinct help to medical practice in general and to the general practitioner in particular. Furthermore, if the movement is encouraged and the habit of regular examinations grows, there is no question but that we will have taken another important step along the road of "Preventive Medicine".

THE DOCTOR'S RESPONSIBILITY

After a personal visit to Rhode Island by one of its editors to study at first hand the operation of the Rhode Island Cash Sickness Act, *Survey Midmonthly*, a national publication, reports in its December issue about the program under the title "Money While You're Sick". In view of the criticisms levelled at the RHODE ISLAND MEDICAL JOURNAL for its editorial inquiry last month regarding the medical administration of the act, we note the following interesting comment made in the *Survey Midmonthly* article:

". . . . . Rhode Island physicians undoubtedly have some real grievances. It is not very flattering to prestige to have signed a form asking for continuance of benefits only to have the patient called in for examination by another doctor. Moreover, though the family doctor's decision to back a patient's claim for further benefits may be based on his knowledge of the patient's total physical condition, the board's examiners are concerned only with the patient's progress in overcoming the particular illness mentioned in the original application.

"In many ways the family doctor is actually the scapegoat of the program. If his patient has a tendency to malinger, he is faced with a dilemma of signing a claim against his own better judgment or losing a patient forever. On the other hand, though the law has been interpreted to mean that benefits are payable only to those unable to work, a doctor may find that his patient, though able to perform *some* work, is not yet well enough for the job he was on when he fell ill. In such instances, if continued benefits are disallowed, the patient is apt to go back to his old job before he is in condition for it, thus risking a physical relapse."

NEW ENGLAND HERITAGE

The action of the medical societies of New England in uniting for a discussion of the legislation proposing a federal system of medical and hospitalization benefits, and thereafter issuing a concise, clear-cut, critical statement of the problem, indicates a healthy expansion of the old New England principle of holding a town meeting to appraise fairly an important problem.

The statement itself is a document that warrants the attention of every citizen. It makes no compromise with the forces who would revolutionize the habits of the people of this area in an experiment that is far from sound. It is not merely a negative attitude regarding the proposed legislation. Instead it takes a definite stand in favor of free enterprise, the adoption of the insurance principle, and the value of cooperative effort between the Profession and government authorities for the solution of the health problems of the people. Significantly it strikes at the root of much of the trouble concerning the distribution of medical care, and it offers a solution which it believes in keeping with the thinking of the New England people.

The settlers of this part of the country were a healthy body of people, well-fitted to endure the privations and hardships of the wilderness, and at the same time well qualified to care for one another in the stress of ordinary family sickness. That heritage of self-reliance for the healthy and full assistance to the sick has never been lost.

However, the heritages of New England are not provincial. They have been carried to every part of the country to which settlers departed from here. Therefore we are sure that the statement of our medical societies at this time will strike a responsive chord with the people of every state.

MILITARY ANNOUNCEMENTS

ASSIGNMENTS

LIEUT. WERNER SEGALL, MC, Tilton General Hospital, Fort Dix, New Jersey

TRANSFERS

CAPT. PASQUALE J. CELESTINO, MC, 0461483, APO 85, Fort Dix, New Jersey

MAJOR J. A. DAILEY, MC, 0324751, Cushing General Hospital, Framingham, Massachusetts.

CAPT. ROBERT DREW, MC, 103rd F. A. Med. Det., Camp Blanding, Florida.

LIEUT. (j.g.) WALTER R. DURKIN, MC, USNR, U. S. Naval Training Station, Medical Department, Building 109, Great Lakes, Illinois.

LIEUT. ROBERT L. FARRELL, MC, 63rd Inf. Division, Camp Blanding, Florida.

LT. COMMANDER JOHN D. HUBBARD, MC, USNR, Navy 231, c/o Fleet P. O., New York, N. Y.

MAJOR HUGH E. KIENE, MC, O-469150, 96th General Hospital, Camp Maxey, Texas

CAPT. LOUIS D. LIPPITT, MC, O-1696239, APO 4950, c/o Postmaster, New York, N. Y.

MAJOR RALPH D. RICHARDSON, MC, 1696223, APO 4716, c/o Postmaster, New York, N. Y.

LIEUT. FREDERICK RILEY, MC, Post of Medical Officer, V-12, Brown University, Providence, R. I.

CAPT. W. T. VAN HUYSEN, MC, 0470909, APO 4916, c/o Postmaster, New York, N. Y.

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

WOMEN IN INDUSTRY

EVER SINCE the war began women have entered industry in increasing numbers and there is no indication that there will be a lessening of women in industry, rather the reverse is true.

The employment of women workers presents distinct problems different from those involved with male employees. The industrial physician should give important consideration to the limitations of the female employee's ability. Women are more susceptible than men to fatigue. In a joint statement signed by representatives of eight government agencies, it has recommended (for both men and women) an eight hour day and a forty-eight hour week approximate the best working schedule. One day of rest for the individual in approximately every seven was stated the universal rule. In general it may be stated that working hours for women should be five hours fewer than the maximum for men. Women are ill more frequently than are men. A survey by the National Institute of Health in the winter of 1935 and 1936 included a study of the disability of some two hundred eighty thousand white persons in eight cities. The rate of illness in women from 15 to 64 years of age was about twenty-eight per one thousand in contrast to twenty-two per male workers. Women experienced a higher sickness rate than men in each age group.

It has been fully proven that women are more susceptible to certain industrial poisons than men. Dr. Alice Hamilton states that young women seem to be particularly susceptible to poisons which attack the nervous system. It is also well known that pregnancy may aggravate and accelerate industrial poisoning. Women machine operators seem to be more prone to oil dermatitis.

Careful Selection of Workers Necessary

The above should indicate the need for careful selection of the woman worker to fill the hazardous job. The proper control of industrial hazards will go far toward eliminating occupational diseases of women in industry. Night work for women is not recommended but if it is imperative that women be employed on the night shift certain precautions should be taken. First, make sure the individual is able to work on the night shift. No employee should work on the night shift if there is a history of anemia, respiratory disease, digestive disease or nervous disorder. Women with home responsibilities should not work on the night shift except as an emergency. Young girls should not be placed on the night shift as loss of regular sleep is more serious for young workers. If it is necessary to employ women on the night shift effective health supervision should be instituted. Such workers should be instructed to spend at least seven or preferably eight hours of continuous rest in bed, exercise in the open air, reporting at once to the Medical Department of any disturbances of health.

The Problem of Pregnancy

The most important problem which relates solely to women is pregnancy. Any plant employing women should give this subject serious consideration and a definite policy should be formed regarding it. Pregnant women should be known to the doctor and the nurse in the plant and should be required to see their physicians at regular intervals for prenatal check-up. This is distinctly not a plant

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December 21 at Ashton

An innovation in medical meetings will be inaugurated on Tuesday, December 21, when the Industrial Physicians and Surgeons Society, and the Industrial Nurses Club, will meet at the Ashton, R. I. plant of the Owens-Corning Fiberglas Corporation. The meeting is scheduled for 9:30 P. M., and it will be open to any physician in Rhode Island. Doctors are urged to form groups for the travel to Ashton.

After a tour of the plant to view at first hand industrial health procedures adopted by this outstanding corporation, the groups will conduct a brief business meeting, and will also hear a talk by an out of state authority on industrial medicine.

DISTRICT SOCIETY REPORTS

PAWTUCKET

The monthly meeting of the Pawtucket Medical Society was held in the Nurses' Auditorium of the Memorial Hospital November 18, 1943. There was a change made in the constitution of the society to the effect that all new members must also be members of the state society. After a short business meeting the guest speaker, Dr. Herman C. Pitts, Providence, gave an interesting address on the Medical Aspects of the Wagner-Murray Bill. He brought out several points which showed the disadvantages of the plan in regard to the patient and to the physician, and urged the members of the profession to bring these factors to the attention of the people.

Dr. John F. Kenney addressed the Rhode Island Laboratory Technicians' Club on November 17, on "The Practical Applications of Liver Function Tests." Dr. E. W. Benjamin presented a paper on "The Physiology of the Graham Dye Test and the X-ray Studies of the Common and Hepatic Ducts in the Operating Room and in Post-Operative Studies."

Lt. Edward Foster, Army Flight Surgeon, visited old friends in Pawtucket prior to his transfer to oversea duty.

MARY ELAINE J. ROHR, M.D.

PROVIDENCE

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 1, 1943.

The Association approved of recommendations made by the Executive Committee that the balance of the Blood Transfusion Bureau Fund be transferred to the Association account and that there be added to it to make a total of $750 with which a War Bond shall be purchased in the name of the Association.

The Association also approved of changes in the By-Laws in keeping with the recommendations of the House of Delegates of the State Medical Society to provide for joint membership in the district and State Society at the time of initial application. These By-Law changes were as follows:

Proposed Amendments to the By-Laws

ARTICLE II. MEMBERS

Section 1. *Eligibility*

Any physician who, under the Constitution of this Association is eligible, may apply for membership in the Association *and also in the Rhode Island Medical Society,* and upon the affirmative vote of three-fourths of the members present at a regular meeting, shall be declared elected. Membership shall be granted in accordance with the classifications defined in these By-Laws, *and in the By-Laws of the Rhode Island Medical Society. Upon the election of a member the Secretary shall notify the Secretary of the R. I. M. S. and shall also allocate the proportionate share of the deposit made by the applicant for his assessment to the R. I. M. S.*

ARTICLE III. MEMBERSHIP

Section 1. *Mode of Election*

Applications for membership shall be made in writing to the Secretary and must be endorsed by two active members of the Association, and must be accompanied by a deposit of the amount of the annual dues of this Association *and of the Rhode Island Medical Society,* which deposit shall be returned if the applicant is rejected. The Secretary

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Capt. C. J. Riley Wins Decoration

Too late for the last issue of the JOURNAL was the announcement from the headquarters of the European Theatre of Operations of the award of the Soldiers' Medal for heroism to Captain Clarence J. Riley, MC, of Providence. Details relative to the award were not announced.

He is attached to the Army Air Forces stationed in Iceland, and his action which resulted in the medal award took place on August 5. He enlisted for military service a year ago and following the completion of training as a flight surgeon at Drew Field in Florida he went overseas last June.

PROVIDENCE MEDICAL REPORT

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shall refer each application to the Executive Committee which shall report favorably on it at the next regular meeting, or as soon thereafter as may be, or adversely to the applicant.

Section 11. *Forfeiture of Membership or Expulsion from State Society*

Any member who shall forfeit membership in, or be expelled from, the Rhode Island Medical Society shall automatically forfeit membership in this Association at the same time.

Dr. Alphonse R. Cardi now serving with the Armed Forces of the United States was unanimously elected to active membership in the Association.

The President announced the appointment of Dr. John C. Ham to serve as chairman of the Committee on Tuberculosis to succeed Dr. U. E. Zambarano who had resigned.

The scientific program consisted of a round table discussion of the medical and surgical treatment of varicose veins, phlebitis, pulmonary emboli, bleeding and chronic duodenal and gastric ulcers which was presented by Drs. Arthur Allen, Chief of East Surgical Service, Massachusetts General Hospital, and William B. Breed, Visiting Physician, Massachusetts General Hospital. As part of the program Dr. Allen presented a motion picture in color of femoral ligation. The program was excellently presented and it provoked much general discussion by the members.

FRANK W. DIMMITT, M.D.,
Secretary

WOONSOCKET

A dinner meeting of the Woonsocket Medical Society was held at the St. James Hotel on Wednesday, November 17.

Guests at the meeting included officers of the State Medical Society who participated in an open discussion of the program of reorganization of the State organization. Among those present to address the gathering were Dr. Elihu S. Wing, President-elect of the State Society; Dr. Roland Hammond, former President; Dr. William P. Buffum, Secretary; Dr. Charles J. Ashworth, Assistant Treasurer; and Mr. John E. Farrell, Executive Secretary.

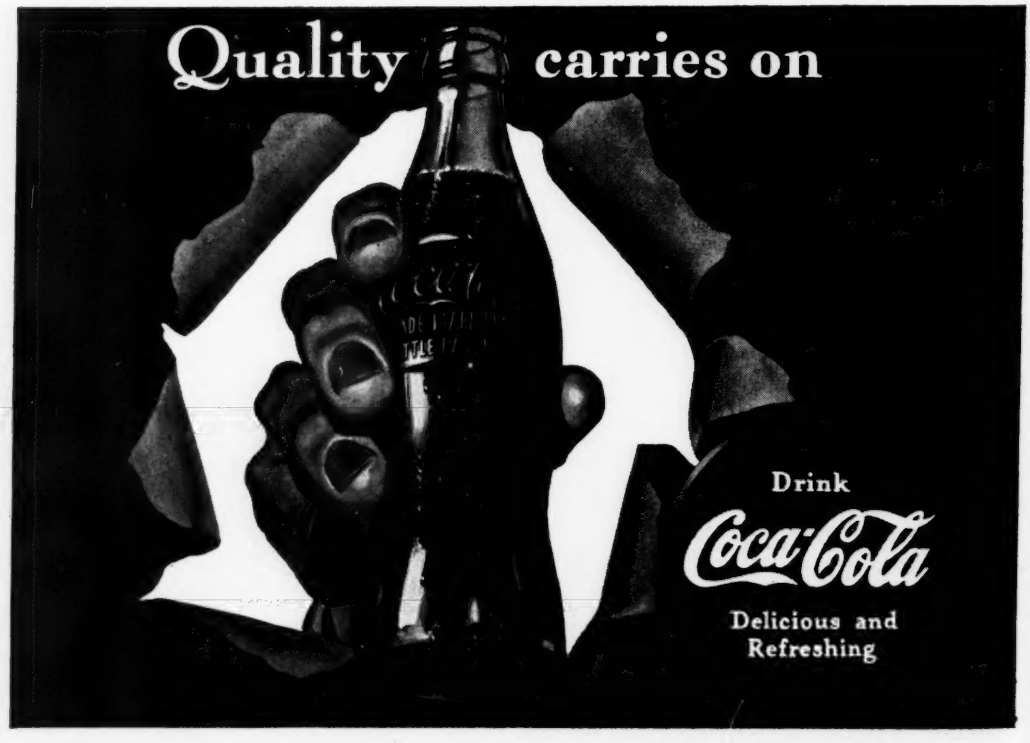
Dr. Guyon G. Dupre, president of the Woonsocket Medical Society, presided at the meeting, and introduced the out of town guests who answered in detail the various questions raised relative to the activities of the State Medical Society. Following the discussion it was moved that an amendment be adopted to the district society by-laws to provide that every member in good standing of the Woonsocket Medical Society be required to also apply for Fellowship in the Rhode Island Medical Society.

THOMAS J. LALOR, M.D.,
Secretary

NEWPORT

Construction was started on September 1 at Newport Hospital on a second story to be built over the present surgery, and on certain alterations to the present administration building to increase the size of the dining rooms, kitchens, and offices. The project has been initiated as the result of a survey by Newport and federal officials which was begun two years ago to determine whether the hospital had sufficient facilities to meet a sudden catastrophic incident, such as a bombing, which would necessitate care for many injured patients.

Original plans called for an estimated expenditure of more than four hundred thousand dollars to provide the needed facilities, but these plans were rejected by the government, and the project curtailed to provide the construction noted above for which a federal grant of $121,000 was made. It is hoped that upon the completion of the present addition the original plan to build a second story over the men's medical and surgical ward to house approximately 40 extra patients may be realized by additional appropriations.



FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

WAR MEETING

A special meeting of the Society was called by the President for Friday, November 26, at the Medical Library. The purpose of the meeting was to review the work of the medical profession in service with the armed forces, and to answer some of the vexing problems relative to the enlistment of additional physicians from Rhode Island for military duty.

Speakers who addressed a sizeable gathering of doctors were Dr. Paul Barton, assistant executive officer of the National Procurement and Assignment Service; Major Norman Harrison, MC, who saw service in the battles of the South Pacific area and who is now stationed at Fort Devens; Lieut. Comdr. Walter E. Garry, MC, USNR, who also had more than 18 months of duty in the Pacific; and Lieut. Thomas Crahan, MC, USPHS.

Particular tribute was paid to Rhode Island for the splendid response that has been made to the appeal for doctors to serve with the military forces, and the contribution of this State was characterized as "one of the finest in the nation."

DR. REUBEN C. BATES HONORED

At a recent meeting of the American Association of Medical Milk Commissions Dr. Reuben C. Bates, of Providence, was elected one of the twelve members of the Governing Council, to serve for a 5 year term. Dr. Bates, for many years secretary of the Medical Milk Commission of the Providence Medical Association, thus becomes New England's representative on the national association's governing body.

INCOME TAX DATA

Members of the Society are reminded that income tax forms are available at the executive office. On or before December 15, the September 15th declaration must be corrected, if necessary, to avoid penalties, and the balance of the 1943 tax as estimated must be paid. Next March it will be necessary to file a complete 1943 return and pay any tax outstanding, and at the same time to file the 1944 declaration and pay one-half. You must also, in March, pay one-half of your unforgiven tax.

Dues paid to the Society are deductible from your income tax.

FELLOWSHIP ROSTER INCREASED

The highest roster of Fellows in the history of the Society has been reached as the result of the recent membership drive, with the total membership now numbering 673. Fellows whose applications have been approved within the past month include the following:

Drs. Robert H. Breslin, Alphonse R. Cardi, Joseph Castronovo, Benedict Chapas, George F. Creamer, John J. Donnelly, Richard H. Dowling, Walter R. Durkin, Bernardino Ferrara, Stephen J. Fortunato, Carl A. Gross, Howard Keefe, Wallace Lisbon, Alan E. O'Donnell, Anthony Romano, George R. Ronne, Paul Rozzero, Giovanni Senerchia, and Arthur O. Trottier.

SCIENTIFIC EXHIBITS FOR AMA SESSION

The Scientific Exhibit at the Chicago Session of the American Medical Association, June 12 to 16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences with particular emphasis on graduate medical instruction for the physician in general practice.

Application blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.

NEWS FROM THE WAR FRONT

SALAAMS FROM INDIA

November 15, 1943

Greetings from the 48th. Still at APO 628 and doing a swell job.

Recent happenings. Capt. Vincent Zecchino recently got his gold leaves and is now Major Zecchino. John Dillon, William Fischer and D. Baronian also got moved up a peg and are now Captains. Among the nurses, Mae Luby and Anna MacIntosh are now First Lieutenants. Expect a few more soon, but that is all for now. Lt. Col. Herman Lawson is now Commanding Officer having relieved Lt. Col. William Mahoney who is on his way back to the states. Major Arthur Martin and Captain Frank Holland are already back in the U. S. A. The rest of the unit are well and doing plenty of work.

The entire outfit expects to get together sometime in December and carry on in full.

Greetings to the Society for a Merry Christmas and a very Happy New Year.

MAJOR EDWARD G. MELVIN

(Lt. Col. William Mahoney is now in Georgia, and Major Arthur Martin and Captain Frank Holland are stationed in Texas.—THE EDITORS.)

RECORDED FOR POSTERITY

When the records of the war are finally written we are certain that the part played by the doctors—and particularly Rhode Island doctors—will take prominence in the reporting. Evidence of this has been forecast already, and we note with interest the latest war story on the Aleutians campaign which speaks of the outstanding leadership of our Major Richard E. Haverly, MC. Written by Howard Handleman, the book "Bridge to Victory" relates the experiences of the expedition against the Japs on Attu Island, where at Red Beach Major Haverly was commended with his command for "exceptionally meritorious service." The work of the field hospital under Dr. Haverly continued to function with marked efficiency, according to the report, and "often under enemy shell fire the personnel of this organization accomplished their mission of caring for the wounded and sick in a most creditable manner. Their efforts undoubtedly saved many lives and will return many soldiers to combat service who might otherwise have been lost or permanently incapacitated."

MAJOR PIANKA TAKES COMMAND

Thus read the headlines of THE SICK CALL, a mimeographed weekly newspaper we received recently from the South Pacific war front. A former intern at the Homeopathic hospital here, and a one time football star at Providence College, Dr. Pianka enlisted early in 1941 with the rank of lieutenant. In June of that year he was named commander of a newly organized ambulance company of the regiment then stationed at Camp Blanding. Since going overseas he has been advanced to the rank of Major. Prior to assuming his new command as head of a medical battalion, effective October 26 Major Pianka was division medical inspector, a post that has been filled by Lt. Col. Charles V. Snurkowski, MC, who led the battalion throughout the Munda campaign.

AT SEA — AND OVERSEAS

From Lieut. William Tully, MC, USNR, comes word that following his indoctrination period at Portsmouth Navy Yard this summer he was assigned to a newly commissioned ship at Boston on October 19, and he is now on sea duty. News of his election to the Society as an active member and receipt of the JOURNAL provided him with a close touch with the homefront. . . . From Captain Richard S. Arlen, MC, comes word that he is "somewhere in England, attached to a Reconnaissance flight squadron as a flight surgeon . . . having our share of the excitement . . . and looking forward to the day when I will be home once again."

MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:
Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:—

AUTOBIOGRAPHY

Fred H. Albee—A Surgeon's Fight to Rebuild Men. N. Y., 1943. Davenport Collection.

COMMUNICABLE DISEASES

Gaylord W. Anderson & Margaret G. Arnstein —Communicable Disease Control. A Volume for the Health Officer and Public Health Nurse. N. Y., 1941.

MEDICINE, history of

C. D. Haagensen & Wyndham E. B. Lloyd—A Hundred Years of Medicine. N. Y., 1943.

REHABILITATION

William B. Doherty & Dagobert D. Runes, editors—Rehabilitation of the War Injured. A Symposium. N. Y., 1943.

BOOK REVIEW

A HUNDRED YEARS OF MEDICINE by C. D. Haagensen and W. E. B. Lloyd, Sheridan House.

Physicians should know more of their background. The many details of subject matter that they are forced to cram into the tablets of their mind undoubtedly make it difficult for them to pay much attention to history. And it is to be feared that they are occasionally like the one who told us, "All I have time for are surgery, golf and bridge."

This book should encourage these harassed individuals to become acquainted with the stories of the development of medicine, such a large part of which has occurred in modern times.

The American author, Dr. Haagensen of the Presbyterian Hospital, in New York has said that his part has been written with the medical student primarily in view. It is safe to say that older physicians would be reminded pleasingly of much that they had only vaguely been aware of, many incidents would be news to most of us and the laity would find it usually easy and engrossing reading.

Dr. Haagensen remarks in the preface that meat is always better with a little sauce. He doesn't share our reminiscent enthusiasm for the essential flavor of rare roasts and steaks; but these are of course all made dishes and he has put them together with the skill of a French chef.

The first short chapter tells us of medicine from antiquity to the 18th century. Enough for all except the historically minded who can find it excellently treated elsewhere. The next 50 pages are devoted to the 18th century and give us the background from which we can measure our advances. They killed and cured then largely as they had for centuries. What a tremendous progress from their pitiful little armies with their blunderbusses, and their doctors purging and puking, to our millions of men today with machine guns and block busters and our physicians with insulin and sulfa drugs.

After this setting of the stage the action begins and most of the remaining book consists of a series of sketches divided rather arbitrarily under medicine and surgery.

Short chapters tell of the development leading to Virchow's cellular pathology; Otto Folin's physiological chemistry tests and Rontgen's discovery of x-rays; Pasteur's and Koch's work; the improvements in modern hygiene and the developments of vaccines, sera, etc. Then a few striking subjects are selected and discussed, as chemotherapy, liver and insulin therapy and the advances in cardiology. The authors disclaim any attempt to be comprehensive. As Dr. Haagensen speaks of adding features peculiar to the American scene we are mildly surprised that the dramatic tale of

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Have You Any Library Books?

The library reports that some of its books issued on loans to physicians have not been returned promptly. Renewals are permitted for any book, but the request is made that all publications be returned to the Library so that they may be made available to all members of the Society.

At the present time many volumes out on loan should be returned.

Also, the Librarian is seeking the return of the following two periodicals:

Archives of Neurology and Psychiatry, March
War Medicine, February, 1943

WOMEN IN INDUSTRY

continued from page 303

physician's responsibility but should be referred to the family physician. It is the plant physician's responsibility, however, to insist that the worker attend to her health by a monthly visit to her family physician or to some prenatal clinic of her own choosing. Pregnant women should also be given sufficient time off previous to delivery in order that she may be able to go through the period of parturition with a minimum amount of disturbance.

It should also be ascertained that the pregnant woman is not exposed to occupational hazards and that she be not employed on a shift between twelve midnight and six A. M. in the morning nor be employed for more than eight hours a day or forty-eight hours a week. Preferably her hours should be reduced to forty hours per week. In the opinion of some writers it is necessary that pregnant women have two ten minute rest periods during the work shift at which time she may have an opportunity for securing additional nourishment as desired. Naturally, occupations that require heavy lifting or other heavy work should be barred from pregnant women also occupations involving continuous standing and moving about. Exposure to toxic substances such as aniline, benzol, toluol, carbon disulphide, carbon monoxide, chlorinated hydrocarbons, lead and its compounds, mercury and its compounds, nitrobenzol and other nitro compounds, phosphorus, radio-active substances, x-rays, turpentine, and other toxic substances should be avoided.

After delivery all women should be granted an extension of at least two months' leave of absence. If complications of delivery or of post-partum period develop a woman should be granted a reasonable amount of time beyond this period upon presentation of a certificate from her attending physician.

NOVEMBER MEETING

A joint meeting of the Rhode Island Society of Industrial Physicians and Surgeons and the Industrial Nurses Club was held at the Rhode Island Medical Library on November 16. Following separate business meetings the groups assembled in the auditorium to hear talks by Mr. Mortimer Newton, chairman of the Rhode Island Unemployment Compensation Board, and Dr. Stanley Sprague of Pawtucket.

Mr. Newton reviewed the work of the Unemployment Compensation Board in the administration of the R. I. Cash Sickness Act, and answered questions raised relative to the medical operation of the program.

Speaking on the "Management of an Industrial Medical Department, Dr. Sprague gave a very thorough exposition of the ideal medical arrangement in industry, even to consideration of architectural details. He advocated rubber-tiled flooring, pastel-colored walls, sound-proof and enclosed examining rooms, separate toilets for men and women, white and black curtains for the windows, hot and cold running water, open plumbing, hospital beds, a stretcher, and the complete detailed medical equipment necessary to care adequately for the needs of the plant involved.

He also insisted on first aid training for nurses and for the prompt and courteous care of the patient on the first and every subsequent visit.

TUBERCULOSIS RECORD CARD

Printed below is the form for the new tuberculosis case record card to be submitted by physicians henceforth. The new form, simplified for the convenience of the doctor, and yet complete as to essential information for compiling vital statistical data, has been prepared by the Division of Preventable Diseases in cooperation with the Committee on Tuberculosis of the State Medical Society.

DEPARTMENT OF HEALTH
Division of Preventable Diseases
Tuberculosis Case Record

Name.....
Address.....
Occupation.....
Age..... Sex..... Color.....
City.....
Marital status.....

FORM OF DISEASE

Pulmonary
Other forms
Pleurisy

X-ray suggests:	Symptoms suggest:
Activity	Activity
Inactivity	Inactivity
Doubtful activity	Doubtful activity

Sputum examination
Private Physician:
Consulting Physician:

Under care of..... Date.....

PHYSICIANS DIRECTORY

Eye, Ear, Nose and Throat

FRANCIS L. BURNS, M.D.
EAR, NOSE AND THROAT
Office Hours — 1:00-5:00 P. M.
and by appointment
382 Broad Street Providence

FRANK W. DIMMITT, M.D.
Eye, Ear, Nose and Throat
78 Waterman Street Providence, R. I.
Hours: By appointment

JOS. L. DOWLING, M.D.
Practice limited to
Diseases of the Eye
57 Jackson Street Providence, R. I.
1-4 and by appointment

RAYMOND F. HACKING, M.D.
Practice limited to diseases of the eye
105 Waterman Street Providence, R. I.

GORDON J. McCURDY, M.D.
Ear, Nose and Throat
Bronchoscopy and Esophagoscopy
Hours, by appointment
Phone DExter 5550
198 Angell Street Providence, R. I.

BENJAMIN FRANKLIN TEFFT, M.D.
Ear, Nose and Throat
185 Washington Street West Warwick, R. I.
Hours by appointment Phone Valley 229-R

HERMAN A. WINKLER, M.D.
Ear, Nose and Throat
224 Thayer Street, Providence R. I.
Hours by appointment Call GAspee 4010

Cardiology

CLIFTON BRIGGS LEECH, M.D.
Practice limited to
Diseases of the Heart and Circulatory System
Hours by appointment
Phone GAspee 5171
Residence, Warren 1191
82 Waterman Street Providence, R. I.

Dermatology

WILLIAM B. COHEN, M.D.
Practice limited to
Dermatology and Syphilology
Hours 2-4 and by appointment
105 Waterman Street Providence, R. I.

VINCENT J. RYAN, M.D.
Practice limited to
Dermatology and Syphilology
Hours by appointment Call GA 4313
198 Angell Street, Providence, R. I.

CARL D. SAWYER, M.D.
Practice limited to
Dermatology and Syphilology
Hours by appointment
182 Waterman Street Providence, R. I.

MALCOLM WINKLER, M.D.
Practice limited to
Dermatology and Syphilology
Hours by appointment Call DExter 0105
105 Waterman Street, Providence, R. I.

Genito-Urinary

VINCENT J. ODDO, M.D.
Practice limited to
Urology and Urological Surgery
Hours: 2-4 and 7-8 and
by appointment
322 Broadway Providence, R. I.

X-Ray

JACOB S. KELLEY, M.D.
Practice limited to all branches of
Roentgenology
Special attention given to bedside work
153 Smith Street Providence, R. I.
Hours: 10 to 4 and by appointment

BOOK REVIEW

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Beaumont and Alexis St. Martin with its fascinating local color is not included.

In the 14 chapters devoted to surgery America makes a good showing with McDowell's ovariotomy, the discovery of anesthesia, Holmes' paper on puerperal sepsis, which certainly considerably antedated that of Semmelweiss, Fitz's work on appendicitis and Harvey Cushing's magnificent development of neurosurgery. We wonder why the story of nursing comes under surgery—the answer presumably is, why not, it had to be put in somewhere. All these tales are delightfully told. It is too bad that many had to be left out.

There is one decidedly queer thing about this volume. With a wealth of interesting illustrations it was apparently left to the book binder to insert these entirely by chance. Opposite the discussion of x-rays is a caricature of Virchow, while a portrait of Rontgen faces louse born diseases; the yellow fever mosquito graces the story of vitamins. With the exception of Robert Koch's portrait not a picture is associated with its adjacent subject matter.

The last 50 pages are devoted to the New Social Aspects of Medicine. Beginning with the 18th century when a Foundling Asylum had only 45 infants survive from over 10,000 and even Queen Anne lost all of her 18 children we now can, out of 1,000 children raise all but 35 to the open age for shooting them,—18 years. The development in medical schools and medical centers is graphically pictured as well as the methods by which patients records are now followed allowing the evaluation of our work. Specialization, group practice, the price of medical care and medical insurance are taken up briefly with the citation of some figures. The author has refrained from taking a decided stand on the question of socialization associated with the discussion of these matters and the reviewer will join in that refrain.

This is a delightful book giving an excellent impression of the development and state of modern medicine. Once again we urge its reading.

PETER PINEO CHASE, M.D.

Providence Association Nominations

In accordance with Section 8 of the By-Laws of the Association which reads in part:

". . . it (the executive committee) shall act as a nominating committee and present at the meeting next preceding the Annual meeting a list of officers to be elected at the Annual meeting. Any counter nominations from the Association must be in writing signed by ten members of the Association, and delivered to the Secretary at least ten days prior to the Annual meeting . . ."

The Executive Committee hereby submits the following recommendations to be voted upon by the membership at the Annual Meeting on Monday, January 3, 1944:

Office	*Candidate Proposed*
President	Albert H. Jackvony, M.D.
Vice President	B. Earl Clarke, M.D.
Secretary	Frank W. Dimmitt, M.D.
Treasurer	Herbert E. Harris, M.D.
Executive Committee (for 5 year terms)	Emery M. Porter, M.D Kalei K. Gregory, M.D.
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BOOK REVIEW

HOLT'S CARE AND FEEDING OF CHILDREN by L. Emmett Holt, Jr., M.D. Appleton-Century.

The revised 1943 edition of Holt's "Care and Feeding of Children" which has just been published brings up to date all the latest ideas on this subject.

The method used of placing a question, which might well be asked by a mother, at the head of a paragraph, and then answering it in simple terms which a layman can easily understand, is an excellent way of solving most of the simple problems of health and disease which worry parents.

The inclusion of the latest feeding routine, the care of children in illness, and the section on behavior problems is especially valuable because of the shortage of physicians due to the war and the high nervous tension under which both parents and physicians are laboring.

This book may be recommended to parents with confidence. It will aid them in taking intelligent care of their infants and children.

R. M. LORD, M.D.

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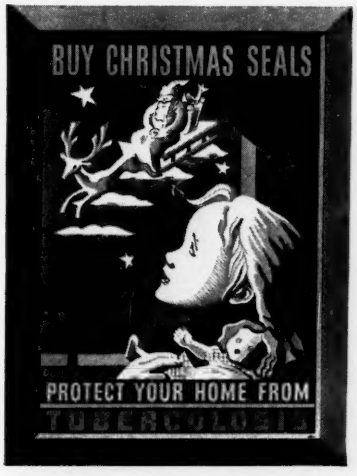

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THE RHODE ISLAND MEDICAL SOCIETY

a Poor Scholar . . . because of a Poor Breakfast

MANY a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, — or less — small wonder that he is listless, nervous, or stupid at school.

Pablum offers a happy solution to the problem of the school-child's breakfast. Mothers who learn about Pablum from their physicians are delighted to serve it, for it needs no cooking and can be prepared in a minute at the table — more quickly than many less nourishing foods. Right now, this feature is especially valuable in homes where the mother is engaged in war work. Pablum not only ends the bane of long cooking of cereals but in addition furnishes a variety of minerals (calcium, phosphorus, and iron) and the vitamin B complex. It is an excellent vehicle for milk.

PABLUM is rich in calcium and iron, minerals likely to be deficient in the school-child's diet yet needed in more than average amounts during childhood. Numerous clinical studies have demonstrated that Pablum gives good weight gains and increases hemoglobin values in both normal and sick infants and children. Reprints on request of physicians.

Pablum (Mead's Cereal thoroughly cooked) is a palatable cereal enriched with vitamin- and mineral-containing foods, consisting of wheatmeal, oatmeal, wheat embryo, cornmeal, beef bone, alfalfa leaf, brewers' yeast, sodium chloride and reduced iron. (The oatmeal form of Pablum is called Pabena.)
MEAD JOHNSON & COMPANY, EVANSVILLE 21, IND., U.S.A.

"TOMMY, that's the third time this week you haven't learned your lesson. Why don't you listen to me when I tell you how to work the problems?"